



This form should be utilized for Blue Cross Medicare Advantage HMOSM and Blue Cross Medicare Advantage PPOSM Psychological and Neuropsychological requests. Provider must call BCBSNM Medicare Advantage at 877-774-8592 or 877-688-1813 (DSNP) to verify benefits. Please complete all sections of the form and fax to BCBSNM at 505-816-4902.

Request Submission Date: _____ Requested Testing Start Date: _____

Patient and Subscriber Information	
Patient Name _____	Date of Birth _____
Subscriber Name _____	Subscriber ID # _____ Group # _____

Testing Provider Information	<input type="checkbox"/> Medical Practitioner	<input type="checkbox"/> BH Practitioner	Place of Service	<input type="checkbox"/> Outpatient
Name _____	Licensure _____	NPI# _____		
Address _____	City _____	State _____	Zip _____	
Email Address _____	Phone # _____	Fax # _____		
If requesting neuropsychological testing, are you a board certified neuro-psychologist?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Referral Information	Who referred the patient for testing? Name _____
Relationship to patient (i.e. PhD, PCP, Therapist, Medical Director, Parent, Psychiatrist, Teacher, School, etc.) _____	

Assessment History
Have you met with the patient to complete a diagnostic evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has a diagnostic evaluation been completed by another provider? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, the diagnostic eval was completed by? Name _____ Date _____ License Type: _____
Has the patient had previous psychological testing? <input type="checkbox"/> Yes, when? _____ <input type="checkbox"/> No <input type="checkbox"/> Not sure
Focus of Previous Testing: _____

Current or Provisional Diagnosis
Current DX — Please include all DSM 5 and/or medical diagnoses that apply.
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____

What clinical/referral question(s) need to be answered by testing that cannot be answered by a diagnostic interview, medical/neurological consult or review of medical records?

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What are the current symptoms and/or functional impairments related to the testing question(s)?





Patient Name _____

Requested Testing

Please include ALL tests that will be administered. If a test has multiple versions (i.e. parent, teacher, self-report), please indicate specifically which will be administered. If using selected subtests from a larger test please indicate which subtests will be administered.

CPT Testing Code Requested:	Total Hrs Requested per CPT Code	Specify names of test attributed to this CPT Code:
1 <input type="text"/>	<input type="text"/>	
2 <input type="text"/>	<input type="text"/>	
3 <input type="text"/>	<input type="text"/>	
4 <input type="text"/>	<input type="text"/>	
5 <input type="text"/>	<input type="text"/>	

Total Hours for testing requested:

Other Comments

My signature confirms that I am providing the requested services:

Signature _____ Date _____

Such services are funded in part with the State of New Mexico.

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